Inhaled corticosteroids or montelukast as the preferred primary long-term treatment for pediatric asthma?

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In Table 1 there was a typographical error in column 4 (Age range) for the study referenced as Bisgaard 2005 [ref. 3]. The age range is shown as 6–12 years; however, the correct range is 2–5 years.

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Table 1 Randomized double-blind clinical studies comparing the long-term treatments of montelukast with placebo in asthmatic children

First author, year	Duration	<i>n</i>	Age range	Design	Montelukast dose	Main outcomes	Results	Funding and conflicts of interest
Knorr 1998 [11]	8 wk	336	6–14 yrs	Multicenter, randomized, double-blind, parallel	5 mg×1 p.o.	FEV ₁ (1.), daytime asthma symptoms, PEF values, beta ₂ -agonist use, nocturnal awakenings, quality of life, B-Eos, school loss, severe asthma episodes, need for OCS, discontinuations because of worsening of asthma, ACD	M improved FEV ₁ compared to P (the least squares mean %change from baseline, 8.2% vs. 3.6% and difference 4.7%, 95% CI: 1.9–7.4, <i>p</i> <0.001). M compared with P demonstrated improvements in beta ₂ -agonist use, %days and %patients with exacerbations, quality of life, parental and combined global evaluations, morning PEF and B-Eos.	Merck & Co., 4/7 authors were employees of Merck & Co.
Knorr 2001 [12]	12 wk	689	2–5 yrs	Multicenter, randomized, double-blind	4 mg×1 p.o.	Safety (1.); exploratory measures of asthma control: diary questions of daytime and overnight asthma symptoms, beta ₂ -agonist or OCS use, use of resources for worsening asthma, overall control of asthma	No differences in clinical or laboratory adverse experiences. M reduced daytime asthma symptoms, beta ₂ -agonist use, and OCS courses compared to P.	Merck & Co., 5/10 authors were employees of Merck & Co.
van Adelsberg 2005 [1]	6 wk	256	6–24 mo	Multicenter, randomized, double-blind, parallel	4 mg×1 p.o.	Safety (1.); exploratory efficacy endpoints: beta ₂ -agonist use, unscheduled physician or hospital visits, OCS use, exacerbations, B-Eos, discontinuation due to worsening of asthma	No differences.	Merck & Co., 5/6 authors were employees of Merck & Co.
Bisgaard 2005 [3]	12 mo	549	2–5 yrs	Multicenter, randomized, double-blind, parallel	4 or 5 mg×1 p.o.	Number of asthma exacerbations (1.), OCS and ICS use, duration and severity of exacerbations, days without asthma, %patients with an exacerbation, time to first exacerbation, asthma-related resource utilization, B-Eos	M reduced asthma exacerbations compared with P (the average yearly asthma exacerbation rate, 1.6 vs. 2.3, <i>p</i> <0.001). The time to the first exacerbation was longer in the M group compared to the P group. M reduced the rate of ICS use, number of prolonged asthma episodes, and B-Eos compared with P.	Merck & Co., 5/8 authors were employees of Merck & Co.
Spahn 2006 [20]	8 wk	21	9–18 yrs	Randomized, double-blind, parallel	5 or 10 mg×1 p.o.	Forced oscillometry, spirometry, body box plethysmography, symptoms, beta ₂ -agonist use, eNO, B-Eos, S-ECP	M reduced residual volume, residual volume–total lung capacity ratio, Raw, Sgaw, and S-ECP compared P (<i>p</i> <0.05 for all).	Research support, non-U.S. government

n = number of subjects; wk = weeks; mo = months; yrs = years; p.o. = per oral; FEV₁ = forced expiratory volume in 1 s; PEF = peak expiratory flow; B-Eos = blood eosinophil count; OCS = oral corticosteroid; ACD = asthma control days; M = montelukast; P = placebo; CI = confidence interval; ICS = inhaled corticosteroid; eNO = exhaled nitric oxide; ECP = eosinophilic cationic protein; Raw = airway resistance; Sgaw = specific conductance